

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005068	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2012
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 N RITTER AVE INDIANAPOLIS, IN 46219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of a State complaint.</p> <p>Complaint #: IN00100458 Unsubstantiated; lack of sufficient evidence</p> <p>Date of Survey: 09/18/12</p> <p>Facility #: 005068</p> <p>Surveyor: Carol Laughlin, RN Public Health Nurse Surveyor</p> <p>Community Hospital East is in compliance with 410 IAC 15-1.5-5, Medical staff and 15-1.6.8, Surgical services, Hospital Licensure Rules.</p> <p>QA: cloughlin 09/20/12</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1